

# Mount Dora Podiatry

Janet L. Black, D.P.M., P.A.  
Diplomate, American Board of Podiatric Surgery  
Board certified in foot surgery  
Fellow, American College of Foot and Ankle Surgery

## Patient Data Sheet

Please complete entire form.

Today's Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Date of Injury (if appropriate): \_\_\_\_\_ Detail Injury: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced

Parent or Guardian Name: \_\_\_\_\_ Parent or Guardian's Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's name: \_\_\_\_\_ Insured's Social Security No: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured's employer: \_\_\_\_\_ Insured's work phone: ( ) \_\_\_\_\_

Name of primary care physician: \_\_\_\_\_ Date last seen: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

How long have you had this problem?: \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

Has any other doctor treated this problem in the past?: \_\_\_\_\_ Yes \_\_\_\_\_ No

if YES, please explain: \_\_\_\_\_

General Health: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Exercise: \_\_\_\_\_ None \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Type and amount: \_\_\_\_\_

Do you drink alcohol?: \_\_\_\_\_ No \_\_\_\_\_ Yes Amount: Daily / Weekly / Monthly / Yearly (circle one)

Do you smoke?: \_\_\_\_\_ No \_\_\_\_\_ Yes Amount: \_\_\_\_\_ How long?: \_\_\_\_\_

When did you quit?: \_\_\_\_\_

Family History (please list any major illness for family members listed below):

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Brother/s: \_\_\_\_\_ Sister/s: \_\_\_\_\_

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Do you have, or have you ever had, any of the following conditions or illnesses?

No	Yes		No	Yes	
_____	_____	Recent weight changes, weakness, fatigue or fever.	_____	_____	Low back pain
_____	_____	Skin Rashes	_____	_____	Radiation of pain down legs
_____	_____	Migraines	_____	_____	Leg cramps while walking
_____	_____	Stroke	_____	_____	Leg cramps at night
_____	_____	Glaucoma	_____	_____	Varicose veins
_____	_____	Tinnitus, vertigo or ear infections, or hearing problems (circle)	_____	_____	Blood clots in legs
_____	_____	Tuberculosis	_____	_____	Swelling of feet/ankles
_____	_____	Emphysema or COPD	_____	_____	Superficial phlebitis
_____	_____	Asthma	_____	_____	Seizures
_____	_____	Shortness of breath	_____	_____	Numbness in feet
_____	_____	Heart murmur	_____	_____	Depression
_____	_____	Heart problems (Type _____)	_____	_____	Anxiety
_____	_____	High blood pressure	_____	_____	Diabetes
_____	_____	Stomach or duodenal ulcers	_____	_____	Thyroid problems
_____	_____	Hiatal hernia	_____	_____	Anemia
_____	_____	Reflux	_____	_____	Easy bruising
_____	_____	Liver Problems	_____	_____	Bleeding problems
_____	_____	Hepatitis A, B, or C	_____	_____	Blood transfusion
_____	_____	Kidney problems	_____	_____	Positive HIV
_____	_____	Recent urinary tract infection	_____	_____	Chemical dependence
_____	_____	Significant joint pains	_____	_____	Cancer (Type: _____)
_____	_____	Gout	_____	_____	Currently Pregnant
					Other: _____

Please list all surgeries with approximate dates:

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The above information is complete and accurate to the best of my knowledge. I hereby give permission to Janet L. Black, D.P.M., to examine and perform necessary diagnostic testing and treat my foot and/or ankle condition. I authorize photographing of my feet.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date